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~~XI~~  
VOL. ~~XXXIX~~

No. 9

# THE CALIFORNIA ECLECTIC MEDICAL JOURNAL

Incorporating  
THE LOS ANGELES JOURNAL OF ECLECTIC MEDICINE  
AND THE CALIFORNIA MEDICAL JOURNAL

ISSUED MONTHLY

SEPTEMBER, 1918

O. C. WELBOURN, A. M., M. D., Editor

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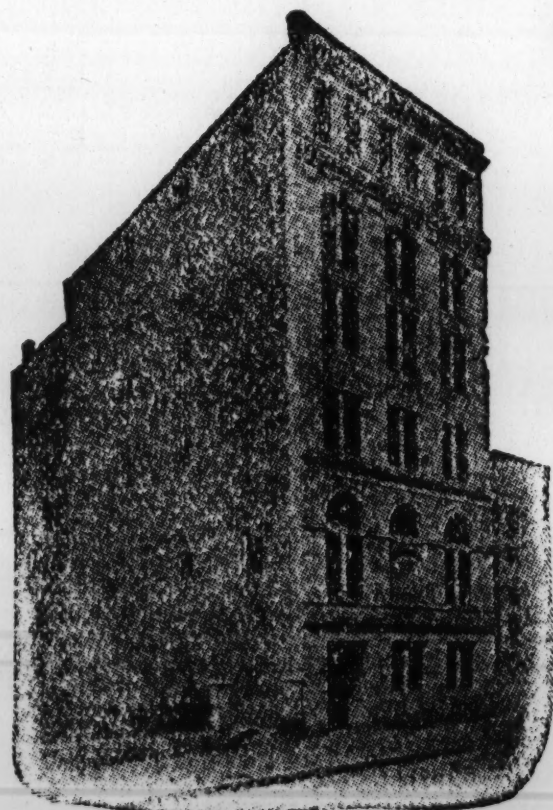
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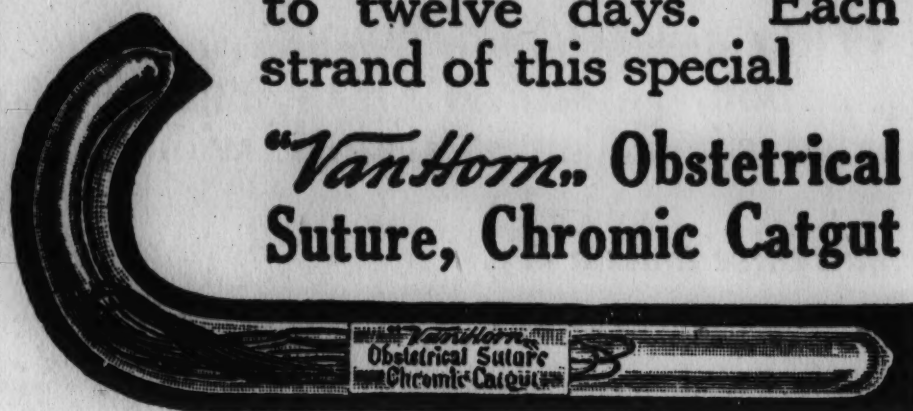
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# The California Eclectic Medical Journal

Vol. XXXIX

SEPTEMBER, 1918

No. 9

## Original Contributions

### SURGICAL TREATMENT OF GASTRO-COLOPTOSIS

O. C. Welbourn, A. M., M. D., Los Angeles, California.

Read before the California State Eclectic Medical Society.

Splanchnoptosis may be defined as the displacement downwards of all the abdominal viscera. Such a displacement may be quite marked and produce no symptoms, the owner believing himself to be in perfect health. On the other hand the displacement may be limited to one organ and that not markedly dislocated, yet the symptoms are severe and persistent. Therefore it is the degree of physical disturbance rather than the degree of displacement which should guide us in devising a method of cure. Inasmuch as these conditions are due to man assuming the erect position without adequate anatomical equipment, it logically follows that should he resume the "all four" position his abdominal organs would remain in the same relative location as at birth. However to do so is manifestly impossible. Sometimes we do the nearest practical thing, namely put the patient to bed for several weeks. In a small percentage of cases such a course of treatment is curative—in the remainder it is palliative only. In a general way the abdominal viscera are hung from the spine in much the same manner that the week's wash is hung from a clothes-line. So long as the line is in a horizontal position everything is neat and orderly, but place such a line on end and the clothes fall into a sausage shaped mass amid much confusion. Each garment drags on one clothespin at one time instead of two or three with great danger that each will tear out in turn as it receives the burden of the entire garment. That man is able to maintain an erect position at all is a striking evidence of his adaptability to his needs.



Gastric prolapse has long been recognized, the physical signs being clear and positive to the examiner though somewhat technical. In recent years the evolution of X-Ray technic has made available a shorter road and one which is much better in that it is possible for the patient to see and convince himself. Having made a satisfactory diagnosis the usual method of procedure is to adjust some form of abdominal support. This should be done under X-Ray fluoroscopy and the results noted. It is essential that the stomach and colon both be held in their proper places in any position of the body. A small percentage of cases can be fitted perfectly and so long as the patient is content to wear such a support no radical method need be considered. But should it prove to be impossible to fit a practical support an operation is in order. An operation for gastro-coloptosis carries a favorable prognosis both as to the immediate hazard and the cure desired, and the patient should be urged to undertake it at an early date. After proper preparation the incision is made between the ensiform and umbilicus through the linea alba or the right or left rectus as conditions indicate. With exposure of the stomach and colon a careful macroscopic examination should be made to determine if complications be present. Such an examination also should be made of the duodenum and hepatic adnexa to exclude concurrent pathology. Also it should be determined at this time if not before, that the kidneys are not prolapsed. Having determined that the patient has a gastro-coloptosis, and that alone, the method of resuspension should be determined. Should the gastro-hepatic ligament be elongated but of firm structure it may be shortened. Or the anterior superior border of the stomach may be attached directly to the under surface of the liver. Or the anterior wall of the stomach at the superior or inferior border may be attached directly to the abdominal parieties. Or the greater omentum just inferior to the transverse colon may be attached to the abdominal parieties. This operation would swing the stomach in a sort of hammock provided the gastro-colic ligament affords sufficient strength. If not it may be strengthened by overlapping. Just which operation should be performed is a matter of judgment. Sometimes two or more should be combined. Care should be taken to determine that the resuspension of the stomach also has suspended the transverse colon. It may be necessary to make a separate suspension of the colon to insure its being retained in its proper position. Having restored the abdominal anatomy to normal the incision is closed and the patient kept in bed a sufficient length of time



to be well on the way to recovery. Also it is of great importance that the patient receive efficient care after leaving the hospital.

### GASTRALGIA

Janet D. Quinn, M. D., Hollywood, Cal.

Read before the California Eclectic Medical Society.

The term Gastralgia is used to express the condition of pain in stomach; whether pain is the result of irritation of gastric nerves, cold, or irritation of undigested food. We often see these cases and sometimes in a very severe form, causing great suffering. Gastralgia, same to stomach as colic to large and small intestines.

**Etiology**—Most common cause of pain in stomach, is indigestion. Babies nurse well and thrive, but some portion of food undergoes decomposition, causes an irritation, generates gas, causes distention of stomach, and in some cases there seems to be great irritation of gastric nerves, causing great pain; may be due to cold. Again we may have cramps in stomach. This causes patient to break out in cold perspiration, faintness, cold extremities and prostration.

**Treatment**—Do not use opiates if possibly avoidable. Wash out stomach with quart of warm water ( $\frac{1}{2}$  teaspoonful baking soda), also high rectal enema; then begin to give your medicine. Nux 1-3 drops in  $\frac{1}{2}$  glass water. Teaspoonful every 5 to 10 minutes for  $\frac{1}{2}$  hour, then teaspoonful every hour for 2 hours—usually gives relief.

**Colocynth**—Pain is gripping; small doses, 1 to 3 drops to  $\frac{1}{2}$  glass chloroform water, teaspoonful every 5 minutes for  $\frac{1}{2}$  hour—then every  $\frac{1}{2}$  hour for few doses.

**Matricaria**—Dram to  $\frac{1}{2}$  glass water. Relieves nervous tension, acts on entire digestive tract.

In nursing children look after diet of mother. Treat your symptoms as they arise in rational manner. Best local applications, dry heat—either by hot flannels or hot water bottle.

**Pathology**—It is supposed that sensory fibers of pneumogastric and solar plexus are involved through distribution of pneumogastric to stomach.

**Symptoms**—Child is uneasy, will not remain in one position, cries out, sometimes limbs drawn up. May be vomiting of food, showing imperfect digestion. Pain comes usually in paroxysms, may last from 5 to 10 minutes; child cries out,



then when pain abates is easy until another paroxysm comes on suddenly.

**Diagnosis**—Gastralgia is usually easily diagnosed, but must be careful to differentiate it from hepatic colic. This will be shown by Icterus, from chronic disorders of gastric intestinal tract, from appendicitis.

### BE THOU CLEAN

John Uri Lloyd, Phar. M., Cincinnati, Ohio.

Readers of this article may recollect the persistence of Dr. John M. Scudder, who, forty years ago and following that date, continuously threaded his lectures with the quotation, "Be thou clean." Many were the side lines that he employed, illustrative of the harm that came from neglect of the physician's person, or of home surroundings. To use a common expression, familiar by reason of its constant application, we will quote: "Cut out dirt."

In those days it was not unusual for the physician to neglect his pocket case, his saddle bags, his medicine vials, and even his own person, this directly applying to the very, very busy physician.

Said Dr. Scudder: "How can a physician ask a patient or patient's attendant to keep himself and his surroundings clean if the doctor shocks one's sensibilities by his own methods?" Clean medicine, clean glasses, clean teaspoons, clean water, clean methods of living, were eternally harped upon by Dr. Scudder, which perhaps led the writer of the present article to be somewhat fanatical in that direction, even to this day.

Said a very well-known pharmacist and manufacturer of sanitary products in going through the laboratory: "I observe the excruciating care that is taken in keeping your still, condensers and chemical apparatus bright, shining and clean. This," said he, as he stood and looked through the laboratory and noted the bright, shining surface of the utensils, "must be expensive. What is the object of this care regarding the outside?"

The reply was: "If it be made important to keep the outside of a container clean, the manipulator will fully comprehend that it is even more important that the inside must be clean. If shiftlessness is allowed in the one direction, it will naturally follow in the other. If no criticism is made of dirt on the surface of a still, carelessness would soon follow regarding manipulations made with that still."



The scriptural injunction, "Be thou clean," lives today as in the day it was spoken, and, although as originally employed the phrase applied directly to life's methods of living, morally principally, the term likewise applies to the material side, and especially to a manipulative medicine laboratory. Possibly the expense necessary to care in this direction would amount to a considerable profit if it could be spared, but, we take it, few purchasers of medicines, physicians especially, would advocate the cheapening of a product by neglect in the direction of dirt admixture. This, we take it, all manufacturers fully comprehend. Dirty food and dirty medicine above all, being undesirable.

Nor need one imagine that the homely term "dirt" is not scientific. The word is aptly expressive; it covers a multitude of sins. Scientific thought, seeking yet finer lines of expression, makes no resistance to the fact that "dirt" is matter out of place. The different forms of dirt may have scientific names, and yet as a "thing" cosmopolitan, be considered as dirt.

Said my mother to me often and often when a child: "Do not pick that pimple with your finger nail; the nail carries a poison." Said she, time and again: "There are two kinds of dirt—one dead and the other alive. The poison in the finger nail is alive; keep your finger nail out of your eye; keep your finger nails clean; be careful how you touch a scab with the finger nail."

Science can be more expressive, although science may give yet finer names to various forms of "live dirt" found beneath the tip of a finger nail. Let us, with this thought in mind, turn to an old number of the Eclectic Medical Journal and reproduce an article that seems to be as pertinent today as then, although today the terms "bacteria" and "serums" have crept into the place of "live dirt."

**"Be Thou Clean.**—In the mad rush now prevailing in the name of science, both enthusiastic youth and unprejudiced age are apt to forget that the term science is not restricted to test tubes and artificial laboratories. The scientific work of men whose deeds stand as foundation stones on which is built a modern superstructure is likely to be either overlooked or forgotten. The young man who reads some of the modern works is often disposed to accept that all outside that book is a fallacy, all behind it vacuity, and that the book in hand began the very scheme of scientific thought. Or, he may believe that the new idea, even if it be a new way of presenting that which is old, has brushed out all the past. He forgets the



injunction that has challenged the ages—'Prove all things and hold fast that which is good.' This is but one phase of wrong thought due to one-sided thought or inexperience, but it is enough to serve as our text, and it is also enough to paralyze the efforts of many good men.

"Whoever believes the word cleanliness is of modern introduction labors under a delusion. It matters not whether dirt be called by one name or another, dirt is not new; it has long been known as dirt. Nor has it been scientifically localized in modern thought only, for in a general sense localized forms of dirt have been defined, one way or another, since before the art of printing. Nor has it been left to the modern microscopist to announce the fact that living dirt under his new name—bacteria or microbes—may produce disease expressions.

"In our boyhood's days the term animalculae covered the whole multitude of living entities in which the microscope now differentiates so many forms of 'living dirt,' for under the term dirt we class matter out of place, be it vitalized or dead.

"Said our observing friend, Dr. W. C. Cooper, to us many, many years ago: 'Cholera is caused by living microscopic impurities in water,' and he did this by reasoning on observed fact. He argued from his experience in the disease that this must be so. 'The cholera germ is generally carried by the water,' he contended, and he cited localities where, under his personal study of cholera, the disease prevailed, and others where it was absent, and observed the difference in the waters used by the respective persons. Then, at last, he wrote in The Gleaner for 1893 an article that sums up the matter as effectively as possible, if one takes fact for what fact is worth in science:

"The cardinal effect to be remembered is that forty-nine out of every fifty cases of cholera are directly traceable to the water tank. In the one case out of the fifty the toxic principle has gotten into the system through food, which has been contaminated by unclean hands. The trouble is to control the habits of the people. Those who are fortunate enough to live on plateaus where only gravel water is drunk will escape cholera. Those who have good, perfectly tight cisterns, and who drink no other water, unless it be gravel or driven well water, will also escape the disease. Those who drink ordinary well water or hydrant water (and the mass of the people do that) are in perpetual danger, unless this water is thoroughly boiled before being drunk. This is troublesome. In the hurry



and bustle of life many will neglect it, and the very poor, who can not afford ice, will risk a drink of cool, fresh water rather than drink the warm, lifeless boiled water. Again, people must travel, must necessarily, for business or other commanding reasons, visit cities where they can not control their dietaries. They are liable to get a drink of contaminated water at the restaurant, or hotel, or the bar. We know how to prevent cholera, if we knew how to get a chance to do it.'

"Let us not disparage the work of the man of today with the microscope, for he draws yet finer lines when he pictures the microbe and the bacteria; but let us not hesitate to do credit to the man, who, from other reasons, knows and who tells the story in words unmistakable.

"But we may go yet further back in the line of living dirt's definition. Take your "Peter Smith's Dispensatory," a work on primitive medicine, published in 1813. Here the argument is made that the **plague** is due to **invisible insects** wafted by the air. Let us quote:

"'In the course of our conversation I asked him what he conceived the plague to be, which has been so much talked of in the world. He readily told me "that it was his opinion the plague is occasioned by an invisible insect. This insect, floating in the air, is taken in with the breath into the lungs, and there it either poisons or propagates its kind, so as to produce that dreadful disease."'

"But some may argue that those who thus spoke are not to be accredited because they did not use scientific terms and methods that now prevail. With this thought in my mind, we close the book, lay down our pen and ponder."

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"Going without" by yourself makes you feel like a martyr, but if your friends or other members of your society are each trying to outdo the other in buying War Savings Stamps you will find that "going without" is a grand and glorious feeling, popular, and worthy of emulation by all truly patriotic men and women.



# THE CALIFORNIA ECLECTIC MEDICAL JOURNAL

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## A PATRIOTIC INVESTMENT

All of us can help win the war for democracy in some way or other, and it is the duty of each of us to be on the look-out for a fitting opportunity to offer his services. Many of our readers have volunteered for active military duty and some already have seen service. This can not be the privilege of all, but it does not detract in the least from the honor due those who compose the "vanguard." They are the elect!

Of the opportunities for services offered to the rest of us not the least is the privilege of adequately supporting those who have gone and are going to the front. This is a very necessary part of our war machine, and it must be carried on systematically and in order. Therefore it is a governmental function, and it is our duty to uphold the hands of those whom we have placed in authority and to make their efforts our efforts. At the present moment the particular work on hand is to replenish the war chest. And it behooves us to not only fill the chest to the brim but to pile it up. Even if it runs over no harm will be done. We may be assured that the Huns are watching this loan and that they will be cheered up or de-



pressed in consonance with its success. We owe it to our boys at the front to show the Huns that we mean business.

### THE LIBERTY LOANS

The United States entered the war on April 6, 1917. Eighteen days later by a practically unanimous vote Congress passed the Liberty Loan Bond bill.

On May 2 the First Liberty Loan was announced, on May 14 the details were made public, and on the 15th the campaign began and closed one month later. The issue was for \$2,000,000,000, the bonds bearing  $3\frac{1}{2}\%$  interest and running for 15-30 years. The bonds carried the conversion privilege, entitling the holder, if he chose, to convert them into bonds of a later issue bearing a higher rate of interest. Four and a half million subscribers from every section of the country, representing every condition, race, and class of citizens, subscribed for more than \$3,000,000,000 of the bonds. Only \$2,000,000,000 was allotted.

The outstanding features of the First Liberty Loan were the promptness with which it was arranged and conducted, the patriotism of the newspapers, banks, corporations, organizations, and people generally in working for its success, and the heavy oversubscription of more than 50%. Another notable feature was that there was no interruption to the business of the country occasioned by the unprecedented demand upon its money resources.

The Second Liberty Loan campaign opened on October 27. The bonds of this issue bear 4 per cent interest and run 10-25 years. They carry the conversion privilege. It was announced that 50% of the oversubscription would be taken. Nine million subscribers subscribed to \$4,617,532,000 of the bonds, an oversubscription of 54 per cent. Only \$3,808,766,150 of the bonds were allotted.

This campaign was marked with the same enthusiastic support of the public as its predecessor. The labor and fraternal organizations were especially active in this campaign, and the women of the country did efficient organized work which greatly contributed to the success of the loan. The men in the Army and Navy worked for and subscribed largely to the loan.

The Third Liberty Loan campaign opened on April 6, 1918, one year exactly after our entrance into the war, and closed on May 4. The bonds of this issue bear  $4\frac{1}{4}\%$  per cent interest and run for 10 years, are not subject to redemption prior to maturity, and carry no conversion privilege. The loan was



announced for \$3,000,000,000, but the right was reserved to accept all additional subscriptions. Seventeen million subscribers subscribed for \$4,170,019,650 of the bonds, all of which was allotted.

A great feature of this loan was its very wide distribution among the people and throughout the Union and the fact that the country districts promptly and heavily subscribed to the loan, in a great measure making up their quotas earlier than the cities. Secretary McAdoo pronounced this loan the soundest of national financing.

A little over a year ago there was some 300,000 United States bondholders; there are now somewhere between 20,000,000 and 25,000,000. Awakened patriotism has made the American people a saving people, a bond-buying people. The effect of the Liberty Loans on the national character, on our national life, on the individual citizen and our home life is immeasurable—of incalculable benefit. Not less incalculable is their effect on the destiny of the world as our ships plow the seas and our men and material in Europe beat back the Hun.

The Fourth Liberty Loan campaign will begin Saturday, September 28, and close October 19. No American doubts its success; no good American will fail to contribute to its success. The blood of our men fallen in Europe calls to us; our answer must be and will be worthy of them and our country.

### LIBERTY LOAN

The element of surprise has come to play such an important part in the fighting on the western front that the German press explained the backing up of the late lamented trip toward Paris by charging that "Deserters from our army gave the enemy the time and place of the attack."

One gigantic offensive may be seen in the offing which is violating the accepted rules of the game of war by giving the Huns full information. It is an American drive, and there appears no desire to hide the date, the points of attack and the objectives. It is generally agreed that the operation will be successful, although victory must come with the hardest kind of effort.

The campaign will begin at noon September 28; the front on which the attack is to be made is from the Pacific to the Atlantic, Mexico to Canada; the objectives are six to eight billion dollars and the time allowed is three weeks. The divisions to be engaged include every red-blooded American.

Our part begins now. Plan at least to double the investment you made in the last Liberty Loan because the Fourth will be



at least double the size of the last one. Our boys never lag in the attack. They meet the Boche and his bullets more than half way. Let's back them up with our paltry dollars. Let's give them a square deal. Let's lend as they fight and that means crowd the banks the very first hour of the Fourth Liberty Loan offensive.

### THE PARTIALLY DEAF CHILD: A SCHOOL PROBLEM

By John D. Wright

I assume at the start that our "problem" is not complicated by feeble-mindedness. That is a separate question, and if the state has not divorced it from the problem of deafness, so much the worse for the state and its helpless wards. It is a discredit and disgrace to the educational system.

The term "partially deaf" is so indefinite that we must first establish some limiting classifications before we can practically and constructively discuss the "problem."

I think we may safely assume that no child of approximately normal intelligence will be sent to a special school for the deaf who is able to hear shouted conversation at a distance of five feet. It is not often that we are asked to educate those who can hear shouted conversation at a distance of one foot. In my opinion, any pupil that can do that should be equipped with an acousticon, with a cord long enough to permit putting the transmitter near the teacher, and be given a fair trial in a suitable school for hearing children. If this proves unsatisfactory, then the child may be transferred to a special school for the deaf, but should continue to use the acousticon under conditions that will enable his ears and his eyes to supplement each other. We must remember, however, that a degree of deafness that permits an adult who formerly heard normally to still hear shouted conversation at a distance of a foot would, in the case of a child, prevent that child from ever learning to speak or understand speech without very special attention. Yet that power of sound perception, though too small to enable the child to acquire language and speech as children ordinarily do without conscious effort, is sufficient to make it possible to teach the child to hear and to develop the speech and language centers of the brain through the normal channel of the ear.

If those in charge of the schools for the deaf only realized how much easier it is to teach language and speech through even very imperfect hearing than through the senses of sight and touch alone, and also realized how slight an amount of



residual hearing can be made to serve a very useful purpose, they would do far more of this work. The principal difficulty lies in the fact that it is a work which cannot be done in groups of more than two or three, and therefore requires attention that is almost or quite individual. Yet it is surprising how much can be accomplished in a very short daily period. If only 10 minutes a day can be given up to this work of developing the brain centers connected with the ear, the results are worth while.

But it is the school problem of doing the right thing by these children that we are called upon to consider today, and what would be comparatively simple if we had only a score of pupils to deal with becomes much more complicated where there are from 200 to 500.

Let us suppose that there are 300 pupils in the school. During the past 23 years an average of 35 per cent of the pupils in my small private school have been proper subjects for this auricular training. I believe it is quite possible that one-third of the 300 pupils would be found to have enough power of sound perception to get real benefit from the proper kind of auricular training. Probably one-half of these 100 children could be given the necessary training in groups of two, one-fourth in groups of three or four, and one-fourth would require individual attention, at least during the first two or three months. To provide 10 minutes a day for 50 pupils in groups of two would require 4 hours and 10 minutes, or 35 minutes less than the ordinary teaching day of 4 hours and 45 minutes. To provide 10 minutes a day for 25 pupils in groups of three would require an hour and 20 minutes; and for 25 pupils to have 10 minutes a day individually requires a teacher's time for 35 minutes less than a full day. Two teachers, then, giving auricular training  $4\frac{3}{4}$  hours a day could handle the necessary special work in a school of 300 pupils. It would be better if the work was divided between four teachers, letting each give auricular training half of the school day, as the work is rather hard on the teacher. These two teachers might be paid \$600 each, with board and lodging, and I firmly believe the same amount of money could not be spent in any other way that would so greatly raise the standard of language and speech in the school or do so much to approach the 100 pupils to the normal.

Supposing that the two teachers were available, what would be the best procedure and of what does the "proper auricular training" consist? Before going into a detailed description of exercises, I must call your attention to two basic truths:

First: In order that we may understand a language when



we hear it spoken, our brains require a long course of training. If you and I, with our normal hearing, were set down in a foreign country whose language we had never heard, we would not understand a word that was said, not because we were deaf, but because our brain had not been trained to interpret into ideas the sounds that our ears transmitted to it. Now, a child may have a considerable ability to perceive sound, and yet not hear sufficiently to acquire either comprehension of the ideas associated with the speech sounds or the ability to imitate those sounds. A child of seven, with perfectly normal intellect, was brought to me in January, 1916, who possessed so much power of sound perception that we were able to teach her largely through the ear, and yet she had lived several years among intelligent, speaking persons without acquiring a single word of speech or a comprehension of language. She did not even know that there was such a thing as language. Within four months, largely through auricular training, she was able to speak many sentences and to understand them when they were spoken close to her ear. Thanks to this power of sound perception, that had served no purpose under the ordinary environment of a home, she was able to acquire more and better speech and language in four months than a totally deaf child could have acquired in ten months or more. At the end of the four months she did not actually perceive sound any better than at the beginning, but her brain had been trained to associate language conceptions with the sounds that she had always been able to hear when uttered very near her ear. It was an educational process.

Second: The intensity with which a sound affects the ear varies inversely as the square of the distance between the ear and the source of the sound; therefore, to speak one-half as far from the child enables him to hear four times as well, and to speak one-half as far from the child enables him to hear four times as well, and to speak at one-fourth of the distance causes him to hear 16 times as well. To put it in another way: a child who is 16 times as deaf as a person who can hear natural conversation at a distance of one foot can hear that conversation at a distance of 3 inches, or he can be 144 times as deaf and yet hear at a distance of one inch. Since loudness varies directly as the amplitude of the vibrations, if at the same time that the distance is reduced from one foot to one inch the sound is made twice as loud, the child may be 288 times as deaf and yet hear the sounds well enough to learn to interpret their meaning.

This explains the fact that so many children who possess



enough residual hearing to respond satisfactorily to auricular education are yet too deaf to have made any use of their hearing under ordinary conditions. The ordinary distance of the sounds of daily speech from the hearing organ is so great under normal conditions that even a comparatively slight impairment of hearing in a child prevents the proper development of the brain centers connected with the ear.

The effect of the educational auricular exercises is usually to somewhat increase the actual power of sound perception; but this is not the principal value of the exercises. Any considerable increase in actual hearing power is unlikely, if surgical and medical efforts have been unavailing. The pupil soon **seems** to hear better; but careful examination will show that this is due to an increased ability to interpret sounds and an accompanying increase in attention to them, which is a natural consequence of greater comprehension of their meaning and not to any important improvement in hearing power.

The properly functioning ear receives sound vibrations and transmits those impressions to the brain. These impressions arriving at the brain coincidently with the presence of an idea in the mind, the association is made between the sound and the idea, and that sound or group of sounds becomes a word. If this occurs often enough, a permanent record is made upon the brain and we say we **remember** the word.

The process must be the same with the partially deaf child. We must get sound impressions to his brain at the same time we awaken in his mind the idea for which they stand. In order to do this, we avail ourselves of the laws of sound, as previously outlined. We determine by experiment how near our lips must be to his ear and how loudly we must speak in order that any sound impression may be conveyed to his brain.

Then we must devise a series of exercises that will give the brain as nearly as possible the same training that it gets through the normal hearing of spoken words. Although in the case of the child with normal hearing there is no effort to first present sounds that are most easily discriminated, it is best to do so in beginning the development of the brain through the channel of **impaired** hearing. We therefore choose for our first exercises sounds that, owing to their dissimilarity, are more readily distinguished from each other. If we are dealing with little children of from four to eight years of age, with a very small vocabulary, or no vocabulary at all, we begin by training them to distinguish between three or more sounds, as the clapping of hands, ringing of a bell, a whistle and a shouted *ä*, a police rattle, etc. The simple recognition of the



sound is varied by having them count the number of times the sound is made. If they are too young to have the numbers, they can be trained to hold up as many fingers as the times they hear the sound. This idea is sometimes hard for a little child to get, and in order to be sure that he knows what I am trying to have him do, I may touch him on the shoulder once and have him hold up one finger; then touch him twice and have him hold up two fingers; then three times, and repeat this in different order till he has grasped the connection between the number of fingers he holds up and the number of times he is touched. Then it is not hard to transfer the idea to the number of times he hears a sound.

As soon as he has learned to recognize these different sounds, a beginning can be made with spoken sounds that represent words. A good way to begin this with a little child is to place a toy trolley car, a toy sheep, and toy boat on the table before him and say the words—car, sheep, boat—near his ear and as loudly as is necessary to enable him to perceive the sounds. In the case of a young child, who has not yet developed much power of attention, it may take a week or two to teach him to recognize with any certainty even three words of widely different sounds. Once having accomplished this, the subsequent words will be learned more readily. He will always be interested in his own name, that of his brother and sister or play-fellow, mama, father, or mother, papa (not papa and mama), arm, eye, nose, mouth, run, fly, fall, etc. Very soon a beginning can be made with little sentences: Shut your eyes. Open the door. Shut the door. Shut the window. Open the window. In fact, from now on the process of teaching the child to hear—that is, to comprehend spoken language by means of the ear—follows much the same course as that of teaching him to read the lips. Both results are obtained by brain training—one through the sense of sight, the other through the sense of hearing.

In the cases of older pupils having more understanding of language and greater power of concentrated and sustained attention, the early stages of the process can be passed through more rapidly. But it must not be overlooked that this work makes a severe demand upon the attention of the pupil, and that they quickly weary. Ten minutes at a time is enough for some weeks. If circumstances permit, this can later be extended to 20, or even 30, minutes; but for a long time that should be the limit of our demands upon our pupils for sustained attention to the hearing exercises.

When a considerable hearing vocabulary has been acquired by the pupil, it is usually an advantage to supply him with an



acousticon, in order to extend the distance at which he can hear, and also to enable him to use his ears and his eyes simultaneously. Even a very slight ability to recognize sound is a tremendous help in lip-reading when the brain has been trained to know the significance of the sounds.

I sometimes find the acousticon of service in the very earliest stages, in order to get the child's attention to the sounds. Once this has been accomplished, it has been my experience that the final results are better to use only the unaided voice until a considerable hearing vocabulary has been built up. Then I revert to the instrument, as I have said, to increase the range.

In doing this work it must be remembered that many repetitions of the same words, phrases, and sentences are required to insure a rapid automatic response from the brain. You and I heard words many times before we comprehended their meaning; we heard them very many more times before we uttered them ourselves. Therefore, new words and sentences must not be introduced too rapidly, and there must be very many repetitions. We are dealing with a brain somewhat less developed and alert by reason of its having received thousands upon thousands less impressions, owing to the lack of normal hearing; but the process by which we develop this somewhat inert brain is the same as that by which the normally developed brain is trained, and that is by transmitting to it the sound impressions that we wish associated with a certain idea at the moment when that idea is present in the mind of the pupil.

The order of procedure is:

First: Awaken attention to sounds.

Second: Show that certain sounds are always associated with certain ideas.

Third: Build up a hearing vocabulary; first of words, then of short sentences, and finally of continuous spoken language.

Speak at the greatest distance from the ear and with the softest tone that is possible and yet reach the brain.—From the Volta Review.

## PROPHYLACTIC TREATMENT OF PROLAPSE OF THE BLADDER AND UTERUS

William H. Cary, M. D., F. A. C. S., Brooklyn, N. Y.

I purpose to consider this evening certain principles of procedure in the conduct of labor which tend to preserve the supporting structures of the female pelvis, and to urge the recognition and correction of the conditions during the puer-



pium which favor prolapse, after the unavoidable weakening of these structures incident to parturition. While this subject is incidentally touched upon in scattered portions of our textbooks of gynecology and obstetrics, the compact literature dealing with the etiology of prolapse and its prevention is brief and stereotyped.

Comparatively speaking, operations to prevent or correct the extreme degrees of bladder and uterine prolapse are not entirely satisfactory. New operations are daily devised and old ones modified. They are enthusiastically endorsed by some and rejected by others. Competent operators are securing good results in the early cases; but in the advanced, long-standing cases there is a considerable portion of partial failures, and a still larger percentage of morbidity, even when the anatomical results are acceptable. When a patient presents herself with a bulging rectocele, with a cervix hanging outside the vulva, and a low sagging bladder it is evident that either the patient or her medical attendant has been negligent. There is not the excuse of an insidious symptomless onset.

The injuries which make prolapse possible are sustained, with rare exceptions, during childbirth. It is not always possible to avoid the strains which wreck the supporting fascia of the pelvis. In a large proportion of deliveries, however, much may be done by judicious management to preserve the integrity of these supports. Considerable importance is to be attached to the care of the woman after childbirth. Extreme degrees of prolapse are seldom seen in patients who have been confined and subsequently cared for by the trained obstetrician and gynecologist. There is a reason for an urgent plea to the profession at large, chiefly through better obstetrics, but also through detailed aftercare, to prevent the occurrence of the extreme degrees of prolapse. It is not an exaggeration to say that fifty per cent of the hard-working child-bearing women of the country districts are seriously handicapped in their activities by these untreated conditions. Competent obstetric attendance and early gynecology do more than cosmetics to keep the city woman of the better classes younger than her country sister.

The discussion of this subject is best grouped under two heads: (a) care during delivery; (b) care during the puerperium and later.

Accurate observation of the pregnant woman early enough to acquaint one with abnormalities, and if possible to permit their correction, is the preliminary step. The rotation of a breech into a cephalic presentation before labor, especially in a



primipara is an example. An estimation of the elasticity of the pelvic floor based upon a consideration of age, activity, sports, muscular development and distensibility; the measurement of the outlet, and estimate of the size of the fetus aid one in anticipating the degree of damage threatening the fascia and soft structures. This knowledge has a relative importance throughout delivery. The size of the fetus at the time of delivery is the only factor in this group which may be under control. This has an increasing importance proportionate to the unfavorable aspect of the other two factors. An elderly primipara with strong muscles, a tennis player, or horsewoman with limited elasticity of the vulva will suffer extensive laceration in either a forceps or spontaneous delivery. A narrow outlet renders the likelihood of laceration greater, and a narrow outlet plus a big child, even in the event of elastic soft parts, threaten serious rupture. In fact every combination of these conditions which determines the ability of the parturient canal to adapt itself to the passenger must be considered. Preparedness should be a popular term in obstetrics.

#### Management of Delivery

In general, prolonged, low dragging by fetus or forceps upon the lower uterine segment, or prolonged strain upon the pelvic floor are mechanical factors threatening damage to the upper suspension and lower support. Early rupture of the membranes, especially in the primipara, thereby sacrificing lateral pressure and exaggerating downward push, is an instance. An unyielding cervix dragged low because of this faulty mechanism is the result. In many such cases the insertion of a coneshaped bag is conservative interference. The application of forceps and drag with a cervix still obstructing is generally granted a faulty procedure, but sometimes it is an emergency operation and is trauma of the same nature. If, instead of the forcible laceration thus caused by tremendous drag upon the cervix, frank incisions of the anterior and posterior cervix are made, prior to the pull, and deliberative repair made afterwards, so-called radical interference becomes a protective procedure.

Delivery of the occiput in an unrecognized posterior position, or forceps rotation of a posterior occiput in the pelvic cavity are frequent causes of unnecessary damage to the pelvic structures. In the primipara at term, with ample pelvis, head presenting but not engaged, or early rupture of the membranes with unsatisfactory pains mostly in the back, suspicion of posterior positions should immediately arise,



and early in the first stage effort to confirm this suspicion should be made. More frequently the head engages in a posterior position. For some months in the Obstetrical Department of Brooklyn Hospital, Dr. Pomeroy's method of rotary version above the brim has been practised in certain cases of this kind with gratifying results. Indications for this procedure are presented when a primipara with a posterior position has a long unsatisfactory first stage and the progress of labor is so slow that the patient, in spite of rest under narcotics, becomes exhausted, or retraction ring occurs before the head can be brought to the rotating planes of the pelvic floor, thus demonstrating her inability to terminate the labor. When posterior position is found with membranes intact and with retarded descent and dilatation, the case is allowed to proceed until the cervix will admit the hand. If the patient is now tiring and progress is at a standstill or very slow, the membranes are ruptured and the posterior position is accurately determined under anesthesia. If rotation is done the following method is carried out. After careful cleansing, catheterization, and deep anesthesia, the hand (the left for the left posterior position and the right for the right posterior) is introduced within the uterus. The head is raised out of the brim as the hand is introduced. The baby's face is turned so as to allow the operator's hand to slip by to grasp the occiput in the palm of his hand, with the longer fingers fan-shaped upon the back and shoulders. This starts the rotation with the hand and the arm in an awkward reverse. Then with a rotary motion the R O P position is changed to an L O A. This is done above the brim. A rotation of 180 degrees is done and the head follows the withdrawn hand into the brim in an anterior position in the same diameter of the pelvis as it previously presented. Often a prompt spontaneous delivery takes place or at least an easy forceps operation is ultimately offered. In the cases so rotated about sixty per cent deliver themselves spontaneously. Rotation in this fashion not only shortens labor, but, what is vastly more important, it makes unnecessary the rotation of the long axis of the usually poorly flexed head in the pelvic cavity by hand, forceps, or prolonged drive. Such rotation results in terrific lateral pressure often tearing the pelvic fascia from its side attachments, and constitutes one of the most damaging injuries to which the fascia of the pelvic floor is subjected.

Similar injuries may result from a long drive of the head upon the unyielding perineum. The pelvic fascia is the struc-



ture threatened as well as the muscle. Eternal vigilance in the effort to save the perineum is often misapplied energy. Either lateral rupture or disabling stretching of the fascia may take place without noticeable laceration. If delivery is being prolonged because the opening in the soft structures makes escape of the head impossible without laceration, then a clean incision in the perineum (perineotomy) allows delivery while protecting the fascia from violent rupture and leaves a wound easy of repair. Such incision may be lateral in either sulcus or bilateral. The median incision is the easiest to repair, or if allowed to go unrepaired it is of less consequence than the common irregular lacerations.

Marked prolapse of the bladder results in part because the bladder is torn from its attachments. This damage is often increased no doubt because a partially filled bladder is permitted to sustain the pressure of the muscular effort of expulsion and of a descending part which constantly tends to displace it. This means exaggerated strain upon the vesical supports. A simple and important prophylactic step, then, is to see that the bladder is well emptied during the second stage of labor and that catheterization always precedes operative delivery.

A properly prepared rectum is of the utmost importance to lessen the strain upon certain pelvic structures. Not only does the diminished room posteriorly increase the tension elsewhere but if one has observed the progress of labor when the rectum was partially filled he will have noted an increased trauma upon the rectum.

The importance of repairing lacerations need hardly be emphasized. It should be stated, however, that the desirability of immediate repair should not lead one to an immediate difficult operation under unfavorable conditions when by waiting a day or two a deliberate and far more satisfactory repair may be done.

#### Care During the Puerperium

No arbitrary time can be stated as the proper day to allow the obstetric patient out of bed. The degree of involution of itself is not sufficient guide. The physique of the patient, inherited tendencies, (ask the patient's mother), character of the labor, the injuries or length and degree of tissue stretching, and the recuperative power of the patient and the tissues must all be considered. Control of the patient upon such a basis constitutes important prophylaxis against prolapse. Careful examination of the lying-in patient before she is allowed to be active or on her feet is one of the rudiments of



puerperal care, but is either often neglected or the findings are ignored. In addition to the condition of the pelvic outlet, the position of the fundus of the uterus is of great importance in the consideration of our topic.

Backward falling of the fundus means either a lifted cervix or a flexed isthmus; with inefficient drainage and subinvolution in either case. Therefore a wedge of increased weight and damaged support rests upon the vaginal canal in a position to favor descent. This is not theory but fact. Such a lesion may cause early symptoms suggesting examination and correction of the displacement. However, sometimes no symptoms are complained of and the condition, if routine examination is neglected, continues until prolapse is well established. Not only do I carefully correct any backward displacement with pessary support before the patient is allowed upon her feet, but in patients who have had retroversion at any previous time a pessary is placed as a preventive against recurrence. If tenderness prevents the use of a pessary then the knee-chest position should be faithfully utilized. Early correction of the displacement favors a normal involution of the pelvic structures and should not be neglected. For similar reasons routine examinations should be made six to eight weeks post partum.

Beginning cystocele or rectocele early in the puerperium usually indicates damage that will ultimately require operation. In these cases artificial support during the period of involution may accomplish something. Operation may be deferred until childbearing is over without serious consequences, providing (a) the damage to the fascia is not too great; (b) that the prolapse is not increasing under favorable conditions; (c) that the patient co-operates in preventive measures during the puerperium and subsequent to it.

One of the most frequent errors made and one often productive of prolapse is too early resumption of household cares with frequent lifting of the baby. Vaginal examination of the puerperal woman in the upright position, while lifting a very moderate weight, will teach the lesson. The baby's weight increases so gradually that the mother discovers no reason for less frequent carrying. Here, then, is an etiological factor common to a large class of patients which may be partially controlled by detailed instruction and personal supervision.

An ill-fitting corset which constricts the abdomen at the waist line may play a very important role in producing prolapse when any weakness of the uterine or vesical support exists. The amount of downward displacement of the pelvic contents which a waist constricting corset produces depends



chiefly upon tightness, number of hours worn, laxity of abdominal muscles and weakness of the pelvic supports. The lax abdominal wall and prominent abdomen of the early puerperium prompt a woman to wear a corset at a time when conditions allow a poorly fitting corset to exert its most harmful effect. The skeptic may find proof if he examines the patient in the standing position with the corset removed and continues the examination while the corset is adjusted. Present styles are enlarging the waist and constricting the hips, but the cheaper corsets still have the small waist and this type is the one worn, usually, by the woman who must take up laborious duties at once. Corset pressure is force that must be controlled in the prophylactic treatment of prolapse. Full details cannot be given here. No corsets, except to support waist bands, the first few weeks after delivery (4 to 6) should be the rule. When again allowed a new one should be fitted under careful supervision, or if this is impracticable, instructions should be given as to the adjustment of the old one which will enable it to make the least possible constriction of the waist and lower thorax.

Among factors which may play a part in the production or increase of prolapse during the puerperium, straining at stool should be mentioned. This is of course the result of constipation and may be immediate or remote in its effects. By immediate I refer to the unsatisfactory healing of repaired lacerations resulting from undue strain upon the sutures. By remote, I mean the immense downward pressure which may be exerted upon the pelvic organs daily during the puerperium by the straining of the habitually constipated woman. With involution incomplete and the supports much relaxed from recent delivery or operation, prolapse may gradually result. Measures to relieve constipation (diet, habit, and medication) are called for and instructions to avoid straining are important. For the same reason any active or prolonged cough during the puerperium should receive prompt attention.

The habit of allowing the bladder to go long unemptied, common among women, has only a relative influence in increasing bladder prolapse where some degree of cystocele exists. In examining certain stout patients with the corset in situ and with the bladder filled, I have noticed that the anterior vaginal wall prolapsed far below its usual position. Emptying the bladder diminished the prolapse. I assume, therefore, that a cystocele may be unduly increased by this faulty hygiene.

Finally, so that the importance of the foregoing items shall



be emphasized to the patient, and so that carrying them out shall not be left to the accuracy of the memory, either of the physician or patient, I give the puerperal woman a printed list of instructions which is a very brief summary of the points covered in the concluding portions of this paper.—Long Island Medical Journal.

### SOCIETY CALENDAR

National Eclectic Medical Association meets in Detroit, Michigan, June 18-19, 1918. Dr. W. P. Best, Indianapolis, Ind., President; Dr. H. H. Helbing, St. Louis, Mo., Secretary.

Eclectic Medical Society of the State of California meets in Los Angeles, May, 1918. H. V. Brown, M. D., Los Angeles, Cal., President; A. P. Baird, M. D., Los Angeles, Secretary.

Southern California Eclectic Medical Association meets in May, 1918. Dr. Clinton Roath, Los Angeles, President; Dr. H. C. Smith, Glendale, Secretary.

Los Angeles Eclectic Medical Society meets at 8 p. m. on the first Monday of each month. F. J. West, M. D., Los Angeles, Cal., President; C. Ohnemüller, M. D., Los Angeles, Secretary.

### NEWS ITEMS

Dr. Kenneth Baber, a former graduate of the C. E. M. C., was granted a physician's and surgeon's license at a recent meeting of the California State Medical Board.

Dr. J. H. Sprehn of Reno, Nevada, a former graduate of the C. E. M. C., was granted reciprocity at the June meeting of the California State Medical Board.

Dr. A. E. Scott, San Francisco, graduate of the C. E. M. C. 1883, died on June 14, from endocarditis.

Dr. G. W. Groth, Sierra Madre, is in the Westlake Hospital, where he recently underwent an operation for appendicitis and kidney trouble.

Sneak thieves visited Dr. H. C. Smith of Glendale, last month and took several bottles of solutions from his case. A thief also stole a ring from the desk of Dr. P. M. Welbourn, Los Angeles.

Dr. W. S. Fowler, Bakersfield, was in the city several times last month while Mrs. Fowler was a patient at the Westlake Hospital.

Dr. E. P. Bailey, Long Beach, has returned from a five weeks



vacation spent in Canada and Northern California.

Dr. F. W. West, Los Angeles, was on a vacation last month.

The Los Angeles County Eclectic Medical Society tendered a banquet in honor of Dr. H. V. Brown on July 29. Dr. T. C. Young acted as toastmaster and Dr. West presided. The Society also presented Dr. Brown with a very handsome present. Dr. Mitchell of Louisville, Kentucky, was a guest from out of the city.

Dr. M. A. Welbourn with the A. E. F., was overcome with gas in the early days of the recent big offensive and has been in the hospital recovering from his burns. He is a regimental surgeon and has been in the front lines since February.

Dr. Harry Solomon, a son of Dr. Solomon of Los Angeles, has sailed for overseas with Base Hospital 115.

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# Concerning Echinacea.

**WHAT IS ECHINACEA?** A plant, native to western North America.

**WHAT IS THE THERAPEUTIC STANDING OF ECHINACEA?** In the opinion of renowned laboratory experts who standardize remedies according to physiological processes, Echinacea has no value. (See Lloyd Brothers' Winter Bulletin, 1915, page 13.) In the opinion of physicians who use remedial agents clinically, and who employ it in disease treatment, Echinacea is of exceeding value. (See Lloyd Brothers' Winter Bulletin, pp. 11 and 12).

**WHAT PHYSIOLOGICAL OR POISONOUS QUALITIES HAS ECHINACEA?** It has never been known to kill a creature on the operating table, be it reptile, amphibian or other animal. It seems inactive, physiologically. No chemist has reported that he has obtained from it a toxic agent, or any substance destructive to health. Thirty-eight years' continuous use of Echinacea by physicians in active practice, without a single report of injury or death, proves that it has no unkind action.

**WHO INTRODUCED ECHINACEA?** It was first used by the American Indians, next by the early white settlers, then it became a constituent of a home remedy in Nebraska. At last it came to the attention of Dr. John King, who after special investigation, introduced it under its true name to the medical and pharmaceutical professions.

**WHO WAS DR. JOHN KING?** A physician of unusual talent and education, a believer in conservative medication, an author of international reputation, an American citizen who opposed wrong, however high the authority, and who supported the right, regardless of self-interest. A believer was he in kindness to the sick, a disbeliever in cruelty, to either sick or well, brute or human. The best versed physician of his day in the clinical uses of American drugs, Dr. John King was acknowledged to be. His greatest pride was to serve in the development of American vegetable remedies. His sincerest hope was to see America professionally independent of the rest of the world.

**TRIBUTE OF DR. CHARLES RICE.** This is what Dr. Charles Rice, Chairman for thirty years of the Committee on Revision of the Pharmacopeia of the United States, said of Dr. John King and his great work, the American Dispensatory:

"It constitutes a precious encyclopedia of medical American plants, and their therapeutical uses. It is a very useful work for reference. Its author is as fine a botanist as a judicial observer of therapeutical effects." *Translation from the French of Dr. Charles Rice's "Note sur Certains Medicaments Vegetaux Americains"*.

**WHEN DR. KING SPOKE.** The voice of Dr. King in behalf of a remedy, was no idle word. In the maturity of his experience he used Echinacea in his own family, then in his practice, and when he had thoroughly tested the remedy, he gave to the profession his opinion of the drug.

**A PREDICTION.** Twenty years ago, it was said of Echinacea, "Await the voice of time. If Echinacea stands the test of experience, it will live. If it is inadequate, it will die". Has "Time" spoken?

**THE REPLY.** The most popular American drug today, (1915), as shown by the orders we have received from pharmacists for true pharmaceutical preparations of any American drug, (not compounds or mixtures named after the drug), for the exclusive use of physicians, is Echinacea.

**ECHINACEA TODAY.** Our Winter Bulletin, 1915, pages 11 to 13, presents reports from pharmacologists, conflicting with those from practicing physicians, concerning the therapeutic use of Echinacea. That the laboratory standardizers are correct (see page 13), in that Echinacea is not toxic and will not kill any creature, will be generally conceded. That practicing physicians are not capable of judging of the value of the remedies they use in their practice will be universally resisted.

**WHAT OF THE FUTURE?** Physiological investigators will probably never be able to produce death by the use of any ordinary Echinacea dose. Chemists will probably continue to find Echinacea elusive, so far as the discovery or elaboration of any toxic constituent is concerned. And American physicians who use Echinacea will probably continue to employ and commend it, as they have in the past.

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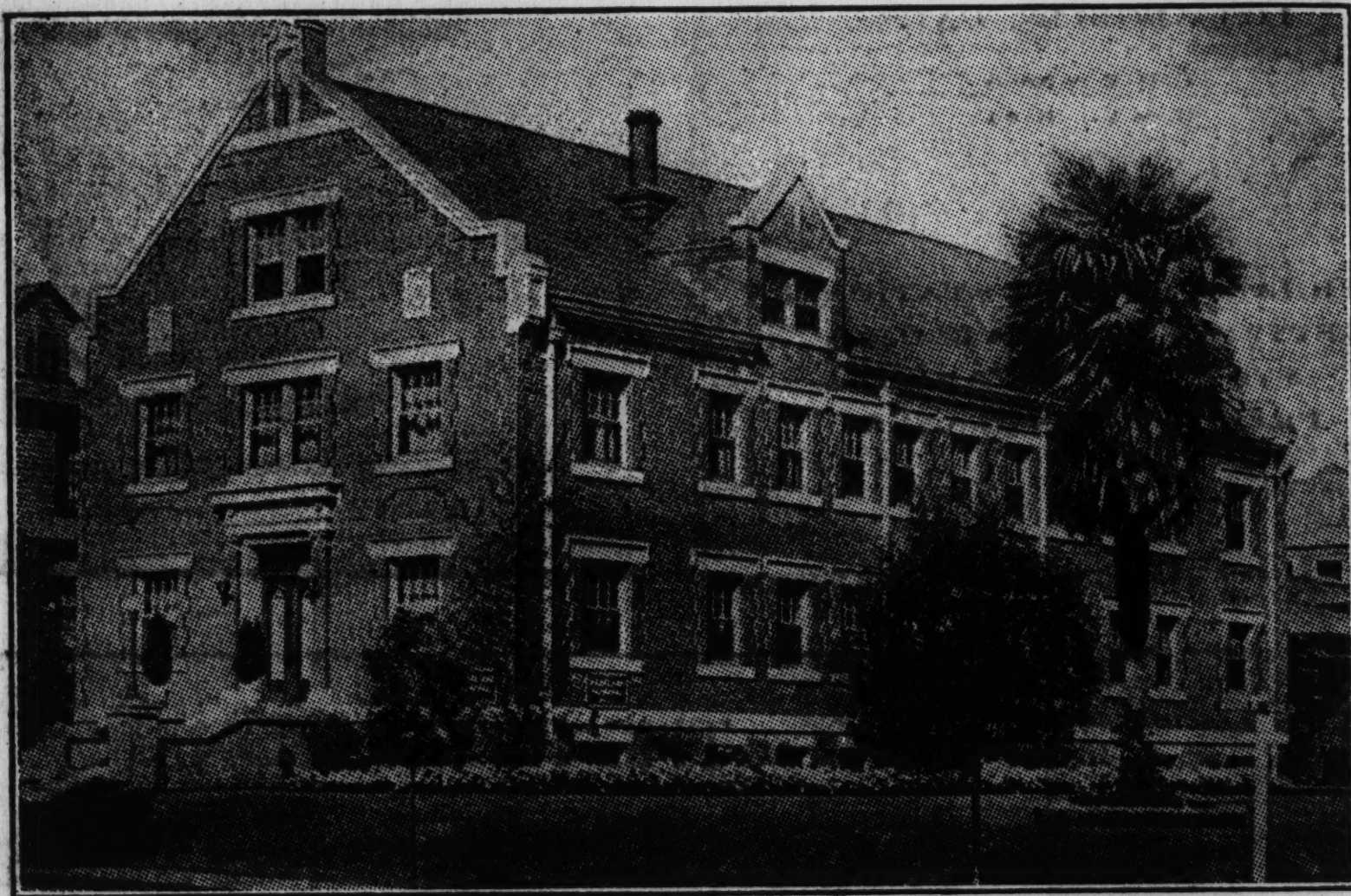
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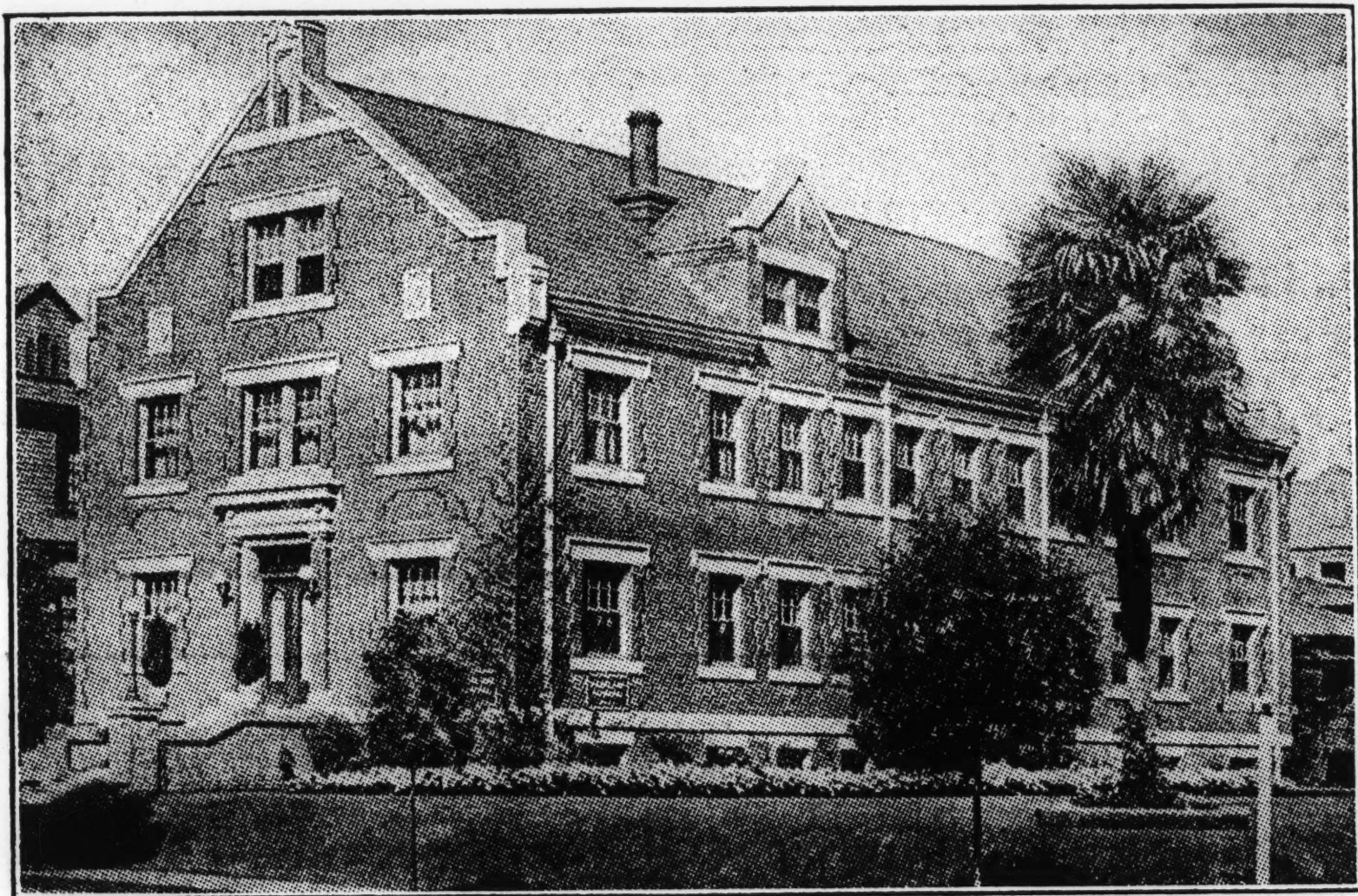
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